STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	C 04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	**234 MANOR CIRCLE ALMA, KS 66401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00085426.	F 000		
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This Requirement is not met as evidenced by: The facility identified a census of 35 residents with 1 reviewed for discharge. Based on observation, record review, and interview the facility failed to ensure 1 (#1) resident's discharge	F 201		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 201	Continued From page 1	F 201		

was necessary for the resident's welfare and that his/her needs could not be met in the facility.

Findings included:

The quarterly Minimum Data Set (MDS) dated 2/4/15 for resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Verbal behavioral symptoms directed towards others occurred 1 to 3 days during the review period. He/she was independent with activities of daily living (ADLs). The resident was not steady but able to stabilize without staff assistance when moving from a seated to standing position, walking, turning around while walking, moving on/off toilet, and surface-to-surface transfers. He/she used a cane and wheelchair for mobility.

The 10/1/14 Care Area Assessment (CAA) regarding ADLs revealed the resident was admitted to the facility due to morbid obesity with a goal to lose weight from his/her current 553 pounds (#) to approximately 400#, his/her inability to care for him/herself such as not able to provide his/her own peri-care after having a bowel movement, his/her chronic knee, hip, and back pain. The resident was not able to ambulate but was able to assist staff with transfers. He/she became very short of breath with exertion and had pain. He/she required staff assistance with showers.

The care plan dated 2/25/15 revealed staff monitored the resident for behaviors due to a history of inappropriate verbal responses and at times behaviors that may interfere with the rights of others around him/her. Staff notified the physician if the resident made comments of

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F 201	Continued From page 2	F 201		

wanting to hurt him/herself or others. The resident required staff assistance for bathing and nail care. Due to his/her weight he/she had knee pain and his/her legs had trouble holding him/her up. Staff provided mobility bars on his/her bed and both a cane and wheelchair for mobility. The care plan did not address discharge plans for the resident.

The notice of discharge letter dated 3/4/15, provided by the facility, revealed the facility notified the resident that it intended to discharge him/her on 4/3/15 (30 days) due to an inability to meet his/her needs related to weight, noncompliance with diet recommendations made by the physician and dietitian, and disruptive behavior in the presence of others. He/she was to be discharged into the care of a family member. The letter included a notice to the resident of his/her right to request a hearing with contact information for the office of administrative hearings, the state, the ombudsman, and state advocacy and protection services for the mentally ill.

Review of the clinical record lacked evidence of documentation by the resident's physician of the care and services necessary that the facility could not provide.

Observation on 4/9/15 at 3:00 P.M. revealed the resident sat on the side of the bed in his/her room.

Interview on 4/9/15 at 3:00 P.M. with the resident revealed he/she received a letter from the facility on 3/4/15 explaining the facility planned to discharge him/her on 4/3/15 to his/her family member. The resident felt the corporate nurse did not like him due to a citation the facility received

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F 201	Continued From page 3	F 201		

regarding his/her room on their previous survey. He/she reported that he/she originally came to the facility because he/she was "bed ridden" at home and he/she desired to lose weight. The resident reported the dietitian at the facility did not understand a low carbohydrate diet, which it was what he/she had desired to do. He/she felt the dietary staff thought of him/her as a burden since he/she required a special diet. The resident stated he/she would be ok with leaving the facility if he/she could get care elsewhere but to his/her understanding the facility had not been able to locate another facility near that could meet his/her needs so he/she could still be near his/her family. The resident said he/she would be okay with staying at the facility. The resident stated he/she was not able to take care of him/herself at home without assistance.

Interview on 4/9/15 at 2:40 P.M. with administrative nursing staff D revealed the resident told staff that he/she desired to leave the facility. He/she reported this to staff in care plan meetings. Staff D stated the facility was not kicking him/her out of the facility. Staff D acknowledged the facility sent the resident a discharge letter showing to discharge him/her on 4/3/15. Staff D stated since the facility was not able to find another facility that could meet his/her needs but they were still working to find that. Staff D also reported the resident ' s family member was not willing to take him/her. Staff D said the reasons the facility had planned on discharging the resident was due to him/her not following the planned diet to lose weight, but instead actually gaining weight. Staff D stated the facility was attempting to find him/her another facility to meet his/her needs since he/she said he/she was not happy at the facility. Staff D stated there was not physician documentation showing the resident ' s

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F 201	Continued From page 4 needs could not be met at the facility. Interview on 4/9/15 at 5:08 P.M. with administrative nursing staff D and administrative staff A revealed the facility did not have documentation from a physician stating the resident needed to leave the facility for his/her welfare or to have his/her needs met. The resident had not improved to where he/she no longer required the services of the facility. The facility did not have documentation from a physician showing other people were endangered or the safety of others were endangered from the resident. Staff A did report the resident had received a discharge letter previously in the year due to non-payment but since then had been paying 25 dollars extra a month to try and get caught up. Staff A and D reported the facility was not ceasing to operate. The facility failed to ensure the resident's discharge was necessary for the resident's welfare and that his/her needs could not be met in the facility.	F 201		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).	F 204		

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F 204	Continued From page 5 This Requirement is not met as evidenced by: The facility identified a census of 35 residents with 1 reviewed for discharge. Based on observation, record review, and interview the facility failed to provide sufficient preparation and orientation to 1 (#1) resident to ensure safe and orderly transfer or discharge from the facility. Findings included: The quarterly Minimum Data Set (MDS) dated 2/4/15 for resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Verbal behavioral symptoms directed towards others occurred 1 to 3 days during the review period. He/she was independent with activities of daily living (ADLs). The resident was not steady but able to stabilize without staff assistance when moving from a seated to standing position, walking, turning around while walking, moving on/off toilet, and surface-to-surface transfers. He/she used a cane and wheelchair for mobility. The 10/1/14 Care Area Assessment (CAA) regarding ADLs revealed the resident was admitted to the facility due to morbid obesity with a goal to lose weight from his/her current 553 pounds (#) to approximately 400#, his/her inability to care for him/herself such as not able to provide his/her own peri-care after having a bowel movement, his/her chronic knee, hip, and back pain. The resident was not able to ambulate but was able to assist staff with transfers. He/she became very short of breath with exertion and had pain. He/she required staff assistance with showers.	F 204		

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F 204	Continued From page 6	F 204		

The care plan dated 2/25/15 revealed staff monitored the resident for behaviors due to a history of inappropriate verbal responses and at times behaviors that may interfere with the rights of others around him/her. Staff notified the physician if the resident made comments of wanting to hurt him/herself or others. The resident required staff assistance for bathing and nail care. Due to his/her weight he/she had knee pain and his/her legs had trouble holding him/her up. Staff provided mobility bars on his/her bed and both a cane and wheelchair for mobility. The care plan did not address discharge plans for the resident.

The notice of discharge letter dated 3/4/15, provided by the facility, revealed the facility notified the resident that it intended to discharge him/her on 4/3/15 (30 days) due to an inability to meet his/her needs related to weight, noncompliance with diet recommendations made by the physician and dietitian, and disruptive behavior in the presence of others. He/she was to be discharged into the care of a family member. The letter included a notice to the resident of his/her right to request a hearing with contact information for the office of administrative hearings, the state, the ombudsman, and state advocacy and protection services for the mentally ill.

Review of the clinical record failed to show evidence of discharge planning and preparation involving the resident.

Observation on 4/9/15 at 3:00 P.M. revealed the resident sat on the side of the bed in his/her room.

Phone interview on 4/13/15 at 3:34 P.M. with

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F 204	Continued From page 7 administrative nursing staff D revealed the facility did not meet with the resident to discuss discharge plans and preparation prior to or after sending the letter. Staff D reported the resident's desire to discharge to another facility or a home environment with assistance was discussed in care plan meetings throughout his/her stay but nothing specific regarding the discharge letter. Phone interview on 4/13/15 at 3:39 P.M. with administrative staff A revealed staff did have conversations with the resident about his/her desire to leave the facility. Staff A stated he/she gave the resident the discharge notice letter but there was no real conversation other than the facility would look for other facilities in the area that could meet his/her needs. Staff A reported the facility did not have a written out plan that was reviewed with the resident and a meeting was not held with the resident to discuss his/her discharge plans. The facility failed to provide sufficient preparation and orientation to ensure safe and orderly discharge from the facility.	F 204		